

TUBERCULOSIS CLINIC AT HARBORVIEW MEDICAL CENTER REGISTRATION FORM							
Name:		PLEASE ANSWER ALL OF THE QUESTIONS ON THIS FORM. USE LEGAL NAMES <u>ONLY</u> – NO NICKNAMES. HAVE YOU EVER BEEN A PATIENT AT HARBORVIEW BEFORE? <input type="checkbox"/> Yes <input type="checkbox"/> No					
DOB:) 25 11 / 1986 (21 / <							
Pt ID #:							
Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary language		Speak English <input type="checkbox"/> Yes <input type="checkbox"/> No Understand English <input type="checkbox"/> Yes <input type="checkbox"/> No			
Last Name		First Name		Entire Middle Name			
Social Security Number - - -		Date of birth / /		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Alias	
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Hispanic				<i>For clinic use only:</i> Ethnic Origin: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic		Country of first asylum: (if not US) Date: / /	
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated				Prior Residence:		If foreign-born; entered US as class: <input type="checkbox"/> A <input type="checkbox"/> B1 <input type="checkbox"/> B2 <input type="checkbox"/> B3 <input type="checkbox"/> Not classified	
Country of origin: <input type="checkbox"/> US <input type="checkbox"/> Not US <input type="checkbox"/> Unknown		If not US, What country: (Country of Birth)				Date entered US / /	
Are you a United States Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No				Alien Number - -			
Are you a veteran of United States military service? <input type="checkbox"/> Yes <input type="checkbox"/> No				Religious Preference			
Patient's Street Address		City		State		Zip	
Home Phone No. () - () - () -		Work Phone No.		Message Phone No.		King County Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Occupation (During the last 2 years)		Employer's Name					
Street Address		City		State		Zip	
Patient's Last maiden name		First		Middle		Same as current name? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mother's Last maiden name		First		Middle			
Father's Name		Last		First		Middle	
1. NEXT OF KIN TO CONTACT IN CASE OF A MEDICAL EMERGENCY (Parent, Guardian, Spouse or closest Relative)							
Last Name		First		Middle		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address		City		State		Zip	
Home Phone No. () - () - () -		Business Phone No.		Message Phone No.			

2. EMERGENCY CONTACT NOT LIVING WITH YOU					
Last Name		First	Middle	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship
					Speak English <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address		City		State	Zip
Home Phone No.		Business Phone No.		Message Phone No.	
() -		() -		() -	
BILLING INFORMATION SECTION: IMPORTANT - THIS SECTION MUST BE FILLED OUT COMPLETELY. FAILURE TO DO SO MAY RESULT IN BILLS BEING SENT DIRECTLY TO YOU FOR FULL PAYMENT. PLEASE PRESENT YOUR INSURANCE CARD OR YOUR MEDICAL COUPON TO THE RECEPTIONIST. A COPY MUST BE MADE IF WE ARE TO BILL SOMEONE OTHER THAN YOU.					
Name of your doctor or clinic				Phone	
				() -	
Street Address		City		State	Zip
Does your insurance company require a written referral from your doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No				For clinic use only	Referral Date _____
If yes, is the referring doctor different than listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No					Referral Reason _____
If yes, please complete the following:					Referral Source _____
Name of Referring Doctor (Who referred you to TB Clinic?)		Phone No.		Fax No.	
		() -		() -	
Street Address		City		State	Zip
PRIVATE INSURANCE					
Subscriber's Name		Subscriber's relationship to the patient		Subscriber's Social Security Number	
				- -	
Name of the Insurance company				Telephone number	
				() -	
Billing Address		City		State	Zip
Group number		Policy identification number			
SECONDARY INSURANCE					
Do you have a secondary insurance company: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Medicare number		Effective dates			
		(A)		(B)	
Medicaid PIC #		Case #		Healthy Options Plan	
THE FOLLOWING INFORMATION IS REQUIRED BY PUBLIC HEALTH-SEATTLE KING COUNTY PLEASE COMPLETE THE FOLLOWING					
Gross monthly income of the entire family				How many people are supported on this income?	
\$					
I certify that the above information is accurate to the best of my knowledge.					
Signature		Date		Check one:	
X		/ /		<input type="checkbox"/> Patient <input type="checkbox"/> Parent <input type="checkbox"/> Guardian	